Review Requirements Checklist
MEDICARE SUPPLEMENT INSURANCE

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
Filing Requirements		
Transmittal Letter	14 VAC 5-100-40	Must be submitted in duplicate, describing each form, its intended use and kind of insurance provided.
	14 VAC 5-100-40 1	Forms submitted and described in transmittal letter must have a number that consists of digits, letters or a combination of both. (Our system limits the number of characters to 20, including spaces, commas, hyphens, etc.)
	14 VAC 5-100-40 2	Must clearly indicate if forms are replacements, revisions, or modification of previously approved forms and set forth the exact changes that are intended.
	14 VAC 5-100-40 3	Certificate of compliance signed by General counsel, or officer of company, or attorney, or actuary representing company is required.
	14 VAC 5-100-40 5	Description of market for which the form is intended.
	14 VAC 5-100-40 6	Duplicate copy of forms must be submitted if company want a copy for its records.. A stamped self-addressed return envelope is required. Send transmittal letter to: Bureau of Insurance, State Corporation Commission, P O Box 1157, Richmond, VA 23218
	Admin Letter 1983-7	Transmittal Letter must include the name and NAIC number of the Company for which filing is made.
Form Number	14 VAC 5-100-50 1	Form number must appear in the lower left-hand corner of the first page of the form.
Full & Proper Corp. Name	14 VAC 5-100-50 2	Full and proper corporate name (including Inc.) must prominently appear on first page or cover sheet of all forms.
Final Form to be Used	14 VAC 5-100-50 3	Form must be submitted in final form and “John Doe” format.
Required Provisions		
Money/Considerations	§ 38.2-3500.A.1	The entire consideration must be expressed in the policy.
Effective – Terminates	§ 38.2-3500.A.2	The time (i.e. 12 PM on effective date) at which the policy takes effect and terminates must be stated in the policy.
Exceptions – Reductions	§ 38.2-3500.A.4	Exceptions and Reductions must appear in the policy with the benefit or in an appropriate captioned section. If exception/reduction applies only to single benefit, then it must appear with that benefit.
DMAS Payor of last Resort	§ 38.2-3500.A.7	Policy must contain statement regarding the status of the Department of Medical Assistance Services as the payor of last resort.
Notice for Policy/Return	§ 38.2-3502	Each policy must contain a notice on first page stating substantially the wording in this section. If parts of notice inapplicable, it may be modified with the Commissions approval.
Entire Contract/ Changes	§ 38.2-3503.1	Provision that this policy, including the amendment and attached papers, if any, constitute the entire contract of insurance. No change is valid unless approved by Company executive officer, endorsed hereon or attached hereto. No agent may change or waive any of the policy’s provisions.

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
Time Limit on Certain Defenses/Incontestability	§ 38.2-3503.2	TLCD – Only fraudulent misstatements may be used after 2 years to deny a claim or void the policy. Incontestable – After 2 years from issue during insured's lifetime, the Company cannot contest the statements in application. Pre-Existing conditions cannot be greater than 6 months for Medicare supplement policies (See 14 VAC 5-170-70.B.1)
Grace Period	§ 38.2-3503.3	Grace period provision must state this policy has a 31-day grace period. During the grace period the policy shall stay in force.
Reinstatement	§ 38.2-3503.4	If renewal premium not received within grace period, policy will lapse. Insured may apply for reinstatement, if accepted insurance starts on approval date. If no disapproval received by 45th day insurance is effective on the 45th day after conditional receipt of premium. Reinstatement will cover only loss from injury after approval date or sickness starting more than 10 days after such date.
Notice of Claim 20 days	§ 38.2-3503.5	Notice of Claim must be given to Company within 20 days after covered loss starts or as soon as reasonably possible. Notice shall include name of Insured and/or Claimant, and the policy number.
Claim Forms	§ 38.2-3503.6	Company must provide Claimant with Claim forms within 15 days. If not, proof of loss requirements can be met by giving the Company a written statement of the nature and extent of the loss within 90 days.
Proof of Loss (90 days)	§ 38.2-3503.7	Written proof of loss must be given within 90 days to the Company. If not reasonably possible to give proof of loss in the time provided company shall not reduce nor deny claim if proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity proof must be given no later than 1 year from the time specified.
Time of Payment of Claim	§ 38.2-3503.8	After receiving written proof of loss, Company will pay monthly all benefits then due. Benefits for any other loss will be paid as soon as proper written proof is received.
Payment of Claim	§ 38.2-3503.9	Benefits will be paid to the Insured if living, otherwise to the beneficiary or the Insured's estate. If paid to the Insured's estate or beneficiary the amount shall not exceed $2000.
Physical Exam & Autopsy	§ 38.2-3503.10	The Company, at its own expense, can have the Insured examined as often as reasonably possible while claim is pending. It may also have autopsy made unless prohibited by law.
Legal Actions	§ 38.2-3503.11	No legal action may be brought within 60 days after written proof of loss has been given. No legal action may be brought after three years from the time written proof of loss is required to be given.
Change of Beneficiary	§ 38.2-3503.12	Insured may change beneficiary at any time except beneficiary's consent is required if designated as irrevocable beneficiary.
Grp. Anticipated Loss Ratio	§ 38.2-3601	Group Medicare supplement policies are expected to return to policyholders in the form of aggregate benefits at least 75% of aggregate premiums collected.

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
Indiv. Anticipated Loss Ratio	§ 38.2-3603	Individual Medicare supplement policies are expected to return to policyholders in the form of aggregate benefits at least 65% of aggregate premiums collected.
Other Provisions		
Misstatement of Age	§ 38.2-3504.2	If Insured's age has been misstated, benefits will be those that the premium paid would have purchased at the correct age.
Other Insurance with Insurer	§ 38.2-3504.3	If Insured has more than one policy with Insurer, Insured may keep the one policy selected and Company will return all premium paid for other such policies.
Conformity with State Statues	§ 38.2-3504.9	Any provision of this policy that on its effective date is in conflict with the laws of the state in which the Insured resides on that date is hereby amended to conform to the minimum requirement of the law.
Intoxicants and Narcotics	§ 38.2-3504.11	Company will not be liable for any loss resulting from the Insured's being drunk, or under the influence of any narcotic unless taken on the advise of a physician.
Definitions	14 VAC 5-170-30 & 40	Definitions used in policy.
Medicare Definition	14 VAC 5-170-40	"Medicare" shall be defined in the policy and certificate.
General Provisions		
Policy not more restrictive than Medicare	14 VAC 5-170-50 A	No policy may be advertised, solicited or issued for delivery if the policy or certificate contains exclusions or limitations more restrictive than Medicare.
No Waiver to exclude Pre-existing conditions	14 VAC 5-170-50 B	No Medicare supplement policy may use waivers to exclude, limit or reduce coverage.
No Duplication of Medicare Benefits	14 VAC 5-170-50 C	No Medicare supplement policy shall contain benefits that duplicate Medicare benefits.
Accident & Sickness Benefits – Same	14-VAC-5-170-70 B 2	Policy shall not indemnify against losses from sickness on a different basis than losses from accidents.
Medicare Changes Policy Automatically changes	14 VAC 5-170-70 B 3	Benefits designed to cover cost sharing amounts under Medicare will automatically change to coincide with any changes to Medicare deductibles and copayment percentage factors. Premiums may be modified to correspond with such changes if loss ratios have been met.
Spouse – Insured upon term of Insured	14 VAC 5-170-70 B 4	Policy shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of the insured, except non-payment of premiums.
Make available Basic Package A	14 VAC 5-170-70 C	Every insurer shall make available basic "core" package to all insureds (Plan A) Insurer can offer any other Medicare supplement Plan but not in lieu of it.
Standards for Plans B thru J	14 VAC 5-170-70 D	This section provides benefits required for each type plan issued. See section of code for benefit standards for each plan.
Designation of Plan	14 VAC 5-170-80 C	Plans shall be uniform in structure, language, designation and format to the plans A-J listed in this subsection.

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
Riders – Signed Acceptance	14 VAC 5-170-150 A 2	All riders added after date of issue which reduce or eliminate benefits shall require a signed acceptance by the insured.
No policy benefits based on UCR	14 VAC 5-170-150 A 3	Medicare supplement policies shall not pay benefits based on "usual and customary" or "reasonable and customary" or words of similar import.
Receipt of Buyers Guide	14 VAC 5-170-150 A 6	Issuers shall provide to Medicare eligible person a Guide to Health Insurance for People with Medicare upon application and acknowledgement of receipt shall be obtained by issuer.
Prospective Payment System for Hospital OP Services	Administrative Letter 2000-9	Coinsurance for hospital outpatient department services will be based on an established fixed co-payment amount for the particular service provided.
Pre-Existing Conditions		
Pre–Existing conditions Definition	14 VAC 5-170-70 B 1	Pre-Existing Definition – 6 months Pre-existing limitation - 6 months.
Pre-existing limitation Separate paragraph	14 VAC 5-170-150 A 4	Pre-existing condition limitations shall appear as a separate paragraph in policy and be labeled as such.
Pre-existing conditions – 63 Days creditable coverage	Administrative Letter 1998-9	Medicare supplement policy applicants that apply not later than 63 days after termination of enrollment and who submit evidence of date of termination with the application are eligible persons. With respect to eligible persons, an issuer shall not: 1) deny or condition the issuance of a policy offered and available for issue to new enrollees. 2) Discriminate in pricing of the policy because of health status, claims experience, receipt of health care, or medical condition. Or 3) Impose an exclusion of benefits based upon pre-existing conditions. If period of creditable coverage is less than six months, the pre-existing condition period may be reduced by the aggregate of the period of creditable coverage.
Eligibility Provisions		
Open Enrollment Guaranteed Issue – Pre – Existing – 6 Months allowed	14 VAC 5-170-100 A	Issuer may not deny Medicare supplement coverage nor discriminate in the pricing of such policy because of health status, claims experience, receipt of health care or medical condition of applicant submitting prior to the 6 month period when individual is both 65 or older and enrolled under Medicare Part B. All plans will be made available to those who qualify regardless of age.
Renewability Provisions		
Med Supp shall be GR no Cancel except non-payment or Material misrepresentation	14. VAC 5-170-70 B 5	Each Medicare supplement policy shall be guaranteed renewable and the issuer shall not cancel or non-renew solely for health status. Issuer shall not cancel or non-renew for any reason except nonpayment of premiums or material misrepresentation.
Renewal Clause – captioned on first page of policy	14 VAC 5-170-150 A 1	Renewability provision shall be appropriately captioned and shall appear on the first page of the policy, and include any reservation of the right to change premiums and any automatic renewal increase based on policyholders age.

REVIEW REQUIREMENTS	REFERENCES	COMMENTS
Replacement Provisions		
Replacing policies – no pre-ex or waiting periods greater that remaining on old policy	14 VAC 5-170-210	When replacing policies – Issuer will waive all time periods applicable to pre-existing conditions, waiting periods, elimination periods and probationary periods to the extent such time was spent under the original policy. If policy is over 6 months old , replacing policy shall not provide any time periods.
Replacement notice required When replacing Medicare Supplement policies	14 VAC 5-170-160 D	Upon replacement of Medicare supplement policy, issuer must provide replacement notice to applicant. One copy of replacement notice shall remain on file with the issuer.
Outline of coverage Provision	14 VAC 5-170-150 C	All Outlines of coverage shall be in essentially the same format as shown in this section.
Notice to Buyer prominent on First page of policy	14 VAC 5-170-180 A 3	Notice to Buyer must appear prominently on first page of policy.

Access to Administrative Letters, Administrative Orders, Regulations and Laws is available at
http://www.state.va.us/scc/division/boi/webpages/administrativeltrs.htm

The Life and Health Division, Forms and Rates Section handles Medicare supplement insurance. Please contact this section at (804) 371-9110 if you have questions or need additional information about this line of insurance.

Review Requirements Checklist
MEDICARE SUPPLEMENT INSURANCE

I hereby certify that I have reviewed the attached Medicare supplement filing and determined that it is in compliance with the Medicare supplement checklist.

Signed: _____

Name (please print): _____

Company Name: _____

Date: _____ Phone No: ( ) _____ FAX No: ( )_____

E-Mail Address: _____